

Netherlands report for the UN World Summit for Children +5 Review

Introduction

In 2004, following the decisions made at the UN World Summit for Children in New York in 2002, the Netherlands produced the National Action Plan for Children 2004. The Action Plan was drawn up following a consultation process involving children, made possible by the Dutch NGO Coalition for Children's Rights. Children were asked for their views on the four priorities covered by the Action Plan: the ability to lead a healthy life, better education, protection and care, and HIV/AIDS and reproductive health. These views were subsequently incorporated into the plan. The Action Plan also discusses how the Dutch government intends to respond to these issues in the Netherlands and abroad.

This report for the UN World Summit for Children +5, which will be held towards the end of 2007, looks at the Action Plan's progress. Ministries closely involved in formulating the Action Plan have also contributed to this report: the Ministries of Health, Welfare & Sport; Justice; Education, Culture & Science; Foreign Affairs; and Social Affairs & Employment.

Chapter 1. The Ability to Live a Healthy Life

2.1 Fighting poverty

The Dutch National Action Plan on reducing poverty and promoting participation pays particular attention to young people. A number of policy priorities have been identified to reduce the chance of inherited poverty, given that 9.2% of minors live in minimum income households. The first priority is *intervention in problem households*. 'Operation Young People' (*Operatie Jong*), launched in 2004, is a joint venture involving several ministries. Its objective is to provide local solutions to the most intractable problems in the development chain for young people, expand coherence within youth policy and simplify and improve integrated steering. The government is also making more funds available for parenting support.

The second policy priority is *participation of children and young people*. The objective is to give children and young people from deprived families the opportunity to participate in a leisure activity which contributes to their personal development.

Reducing educational disadvantage and early school-leaving aims to give pupils a better position in the labour market, thereby reducing the chance of inherited poverty.

In the period 2003-2007 the Youth Unemployment Task Force was set up to *tackle youth unemployment* by creating 40,000 extra jobs for young people. This has so far resulted in 37,000 new jobs.

Income support for parents on the minimum wage aims to encourage balanced income development. An increase in child benefit is planned for 2007, and the introduction of extra child tax credit for 2008. In addition to this universal policy, municipalities can also apply local poverty policy on a *made-to-measure* basis, e.g. covering educational expenses and promoting the benefits of a healthy lifestyle.

Objective	Preventative	Curative
II. Reducing poverty and promoting participation of children and young people	<ul style="list-style-type: none"> - Intervening in problem families - Giving children and young people the opportunity to participate - Reducing educational disadvantage - Reducing the number of children dropping out of school - Reducing youth unemployment 	<ul style="list-style-type: none"> - Income support for minimum income families with children

2.2 Diet

The Dutch government is working to promote good nutrition as part of a healthy lifestyle, in the interests of preventing chronic illness and obesity. The following points relate to babies and young people.

Breastfeeding is the best form of nutrition for babies up to one year old. The aim is for as many children as possible to be exclusively breastfed for the first six months. The Netherlands Nutrition Centre is currently implementing a masterplan to this effect. The Netherlands also endorses the World Health Organisation/UNICEF's Baby Friendly Hospital Initiative which has been adopted by hospitals, maternity care agencies, obstetric practices and youth healthcare services. More than half of all newborns now receive certified care.

At the end of 2006 a revised version of the 'Nutrition for babies and toddlers' bulletin was issued. The bulletin, which contains advice on nutrition for children aged 0-4 years, is aimed at healthcare advisors who work with this age group. At the same time a new, innovative educational resource was launched in the form of the interactive 'Hello World' (*Hallo Wereld*) internet site, which offers information and advice on nutrition and upbringing to mothers.

In order to encourage children (4-12 years) and young people (12-18 years) to eat healthily, the government is supporting initiatives like the *schoolgruitem* project, designed to get

primary school children to eat more vegetables (*groente*) and fruit (*fruit*), and the Healthy Canteen (*De Gezonde Schoolkantine*) project, designed to make healthy food choices in secondary schools easier. These projects are part of the Action Plan on overweight and obesity, prompted by the voluntary agreement between the government, the food industry, the hospitality business, caterers, supermarkets, healthcare insurers, employers and sports associations, the objective of which is a coherent, effective policy on obesity, focusing on healthy eating and sufficient physical exercise.

2.3 Sport and exercise

Sport and exercise are an important for a healthy society in which people remain actively involved for as long as possible. The Dutch government wants to encourage the public in general, and children in particular, to have a healthy and active lifestyle. Young people still do not take enough exercise. According to the Measuring Movement 2002-2004 (*Bewegen gemeten 2002-2004*) trend report, produced by the Netherlands Organisation for Applied Scientific Research (TNO), more than half of all young people meet the Dutch national exercise norm (*Nederlandse Norm Gezond Bewegen, NNGB*) and/or the fitness norm. The NNGB stipulates that 30 minutes of relatively intensive physical activity are required each day, while the formal norm for young people is actually 60 minutes a day. The trend report therefore overestimates the number of young people meeting the norm. The good news is that the percentage of young people who are not physically active is quite low at 2%, while the number meeting the fitness norm is relatively high. The number of young people involved in sport has also slightly increased.

The National Action Plan for Sport and Exercise (*Nationaal Actieplan Sport en Bewegen, NASB*) was set up in 2006 to encourage large-scale public participation in an active lifestyle. It focuses on five important areas: the local neighbourhood, school, work, care and sport, at all levels of society. The School and Sport Alliance (*Alliantie School en Sport Samen sterker*) aims to get children and young people more active, with 90% of schools giving pupils the opportunity to participate in sport in and outside school by 2010. Partnership between schools and sports clubs will be particularly important in achieving this. The NASB will also pay for dance-based pilot projects for inactive students, and projects designed to encourage children to walk or cycle to school.

The Netherlands Institute for Sport and Physical Activity (*Nederlands Instituut voor Sport en Bewegen, NISB*) has been promoting the FLASH (*Fietsen-Lopen-Actiemomenten-Sport-Huishoudelijke klussen*) campaign, financed by the government and publicised through the

media. The aim of the campaign is to maintain the focus on exercise and to teach the public more about why it is important. The FLASH campaign also runs more specialised programmes e.g. for secondary-school pupils.

The Active Netherlands (*NL-actief*) coalition has set up an investigative study into the spatial needs of sport, exercise and active recreation (see the *Ruimte voor sport* report, October 2005). Partly as a result of this, in April 2006 the Minister of Housing, Spatial Planning and the Environment called on municipalities to ensure that there were sufficient play areas for children. Furthermore, TNO is investigating the effects built-up areas have on children's play, exercise and sport behaviour in Amsterdam and Rotterdam, at the request of the government and as part of the Child, Environment and Health Action Plan. As part of 'Operation Young People' (*Operatie Jong*) the theme 'Young people and space' (*Jeugd en fysieke ruimte*) is also being explored. Additionally, major cities and central government signed a declaration of intent in February 2006 on giving the issue of green space higher priority.

In 2004 a number of activities were organised for the European Year of Education through Sport. The emphasis was on young people's participation in a number of sports activities. The success of this project led the government to increase collaboration between schools and sports clubs through the School and Sport Alliance referred to above.

In 2004 the temporary incentive scheme for Neighbourhood, Education and Sport (*Buurt Onderwijs en Sport*, BOS) was introduced. Through the agency of neighbourhood-oriented sports activities, the government is working on improving the situation for underprivileged young people, in terms of health, welfare, education, upbringing or access to sport and exercise. The idea is that this will simultaneously address anti-social and nuisance behaviour on the part of some young people. Collaboration between schools and neighbourhood clubs and sport is central to the project. The BOS scheme will run until 2011 and covers around 400 projects.

The Ministries of Justice and Health, Welfare & Sport are working together through the 'Ethnic minority youth participation' project (*Meedoen allochtone jeugd*) to capitalise on the integration potential of sport in the years to come. The programme, launched in 2006, aims to encourage good upbringing and involvement, connection and integration on the part of young people from ethnic minorities – and their parents – in and through sport. The programme aims to do this by involving young people from ethnic minorities in sports clubs.

This will both increase the likelihood of successful integration and help to counteract the below-average sports involvement of young people from ethnic minorities.

The Sports Fund for Young People (*Jeugd sportsfond*) wants to encourage children from deprived backgrounds to participate in sports clubs. The Sports Fund covers all membership and equipment costs for children who are interested in sport, but whose parents cannot offer financial support. In doing this the Sports Fund is concentrating primarily not on either the parents or the children, but on education, youth care and welfare agencies. Central government is involved in setting up the Sports Fund for Young People in various locations throughout the Netherlands.

The services offered by sports clubs do not always answer society's needs. That is why teenagers so often drop out of sports activities. Through the 'new opportunities in sport' programme, introduced in 2006, the Netherlands governments will help modernise sports clubs, at the sports sector's request, to get young people more involved in sports clubs.

2.4 Vaccination

National vaccination programme

The vaccination rate in the Netherlands remains high. This also applies to municipalities with large religious populations who are opposed to vaccination on principle, where the rate has actually slightly risen. The average vaccination rate of 95% is well above that recommended by the World Health Organisation. Public information on the national vaccination programme (*Rijksvaccinatieprogramma*, RVP) provided by the National Institute of Public Health and Environment targets these groups in particular, in the hope of raising their awareness. In the Netherlands vaccinating children is not compulsory.

In areas where there is a lower vaccination rate, this can be attributed not only to a higher concentration of people with religious objections but also to people who observe the principles of anthroposophy and/or homeopathy and to parents who doubt the effectiveness and safety of the national vaccination programme. The latter group, in particular, is the focus of the policy to increase the vaccination rate in the Netherlands, which aims to give both the general public and, more specifically, professionals and parents/carers adequate, high-quality information.

2.5 Youth health care

The Netherlands has an extensive system of health care provision. Everyone below the age of 19 is offered preventive health care designed to give early warning of deviations from the normal pattern of physical, mental, cognitive and social development.

There is a fixed programme of preventive health care for the under-19s. All children are examined on at least twenty occasions (mainly concentrated in the first few years of life) to ensure that they are developing normally in six different respects. This service is provided locally by Municipal Health Services and baby and toddler clinics and the vast majority of children receive such preventive care: take-up is more than 95% in the first few years of life, dropping to around 80% later.

Youth health care is a joint responsibility of central government and the municipalities. Central government establishes the programme nationwide and promotes high quality implementation. The municipality commissions its implementation, supplements the nationwide programme with activities of specific local relevance and manages the interface with local youth policies.

The nationwide health prevention policy framework includes a number of specific objectives in the case of young people. These include reducing the rate of childhood morbidity (in particular asthma and diabetes) and improving children's lifestyles in order to reduce the incidence of disease in later life. The main priorities are to reduce smoking, obesity, drug use, sexually transmitted diseases and the rate of teenage pregnancy and abortion.

2.6 Youth care

Youth Care Act

On 1 January 2005 the Youth Care Act came into force, constituting an important step towards a more customer-oriented, consistent service. Youth care, as stipulated in the Act, is aimed at young people under 18¹ experiencing serious problems in terms of upbringing and parenting, which cannot be solved through education, youth healthcare services or social work. The umbrella term 'youth care' covers all care given to parents and children in the interests of solving serious upbringing and parenting problems. Care can be given in the

family setting or through a care provider (youth care institution), and is the responsibility of municipalities.

The Youth Care Act has two priorities: 1) improved care for young people and their parents (youth care clients) and 2) strengthening the position of these clients.

Important changes brought by the Youth Care Act are:

1. *The client's need is central*

Youth care must operate in a client-oriented manner. For example, the Act specifies that each client has the right to care and that the client must agree to the care plan. In order to strengthen the client's position the Youth Care Office and the care providers must also ensure that the following are in place: a confidential advisor, a client council (to provide a platform for participation) and a sound complaints procedure.

2. *One central, recognisable gateway to care*

The Youth Care Act gave Youth Care Offices a statutory basis. Each province has its own Office, representing a central gateway to youth care and giving parents and young people a central place to turn to should serious upbringing and parenting problems emerge. Youth Care Offices can provide youth care funded at provincial level, mental health care for young people, care for young people with minor mental disabilities (as of 1 January 2008) and provide civil-law placement in young offenders' institutions.

3. *The Youth Care Act recognises the individual's right to care*

The client has a right to care if a Youth Care Office has recommended this. Sufficient capacity is needed to prevent waiting lists and waiting times from building up. In recent years the government has made tackling this issue a special priority.

4. *Quality*

Care must also satisfy a number of intrinsic conditions. Investments are being made to develop diagnostic instruments and intervention methods. The sector is working on introducing quality systems and performance indicators.

In response to a number of tragic incidents a number of changes are being introduced to further stress the centrality of the child in the care system. The Youth Care Act has been amended, allowing Youth Care Offices to approach a family on the basis of a report received

¹ It is possible to provide care for young people up to the age of 22 if the Youth Care Office feels it is vital to continue helping

from a third party, instead of having to wait until the parents themselves ask for help. Municipalities and provinces have made agreements regarding the coordination of care in the case of families receiving help from a number of care providers in a number of areas (e.g. upbringing, health, housing, work, finance). This change means that the interests of the child are now central in a way they were not before. At the time of writing it is being considered whether the child's interests should be more firmly established in the Youth Care Act.

Youth care in a secure setting

One particular form of youth care, secure youth care, should be given particular attention in view of recent developments. In the Netherlands there are growing numbers of young people requiring treatment in a secure setting as a result of serious behavioural problems. Such treatment is not yet possible within the youth care system, so these young people are committed to young offenders' institutions (*Justitiële Jeugdinrichtingen*, JJIs) under civil law, alongside young people convicted under criminal law.

Mixing young people who have been convicted under criminal law with those who have not is inappropriate. Additionally, adequate treatment capacity is not always available. The Minister of Justice and the State Secretary for Health, Welfare and Sport have therefore decided to introduce separate accommodation and treatment for young people on civil law placements and those detained following a criminal conviction. This will be achieved by amending the Youth Care Act.

When the amended Youth Care Act comes into force in 2007 all young people currently placed in JJIs under civil law will instead be placed in a non-custodial form of secure youth care. The bill allows treatment in a secure facility provided that the Youth Care Office endorses this and that the children's judge issues a secure treatment order.

Adequate treatment capacity for young people with serious behavioural problems will be achieved within three years.

2.7 Euthanasia

Appointment of experts' committee on neonatal termination of life and termination of late-term pregnancy

solve their upbringing and parenting problems.

In 2006 the Minister of Justice and the State Secretary for Health, Welfare and Sport set up an experts committee to advise the Public Prosecution Service on cases in which the life of neonates experiencing great suffering has been terminated or in which late termination of pregnancy has been carried out. The government's objective in appointing the committee is to achieve more openness from doctors regarding decision-making in these cases.

The experts' committee has five members: a lawyer (the chairman), three doctors (sharing one vote) and an ethicist. Based on the standard of due care criteria – as defined by case law – the committee will assess whether the doctor exercised due care in terminating the life of the newborn or the late-term pregnancy. The committee's recommendation will not supersede the Public Prosecutor's decision, but will serve as an expert opinion.

The appointment of the committee of experts will in no way affect the application of the criminal law to such cases. Terminating the life of a newborn experiencing severe suffering is and will remain an offence under article 293 of the Dutch Criminal Code. Similarly, termination of late-term pregnancy is, and will remain, a criminal offence under Article 82a of the Criminal Code.

The letter to the House of Representatives is included as Annexe 1 to this report.

2.8 What does the Netherlands do for children in other countries?

Each year more than a million children die of malaria worldwide, and a further six million under five die of malnutrition or as a result of poor nutrition. Of the ten million children who fail to reach their fifth birthday each year, between two and three million die of diseases that could have been prevented through vaccination. And every year, hundreds of thousands of children die from HIV/AIDS.

The Netherlands is committed to vaccination and immunisation and has supported the Global Alliance for Vaccines and Immunisation, GAVI, since 2000. GAVI pools the resources of the WHO, UNICEF, recipient countries, donors and industry in saving children's lives through immunisation. Vaccination programmes are often the first (and sometimes only) contact that children have with health care.

Malnutrition also needs to be tackled if child mortality is to be reduced. It is therefore important that food aid is distributed to children living in areas affected by disasters, wars

and violence, which is why the Netherlands supports organisations like UNICEF, the World Food Programme (WFP) and the Red Cross.

It is very important that breastfeeding should be a child's only source of food for their first six months. The Netherlands therefore supports organisations working to improve the health of infants, young children and their mothers. Good nutrition and breastfeeding must be promoted in the interests of reducing child mortality.

The Netherlands is also committed to helping children who have fallen victim to HIV/AIDS. Millions of children have died of AIDS or have lost their parents to the disease. Dutch aid is channelled through international organisations such as UNICEF and through NGOs, which distribute food aid and information in developing countries. They also offer medical aid, helping to prevent HIV transfer from mother to child and providing child-friendly HIV/AIDS treatment.

The Ministry favours an integrated approach. This means that the work it is doing to attain Millennium Development Goal 4 (reducing child mortality) is closely coordinated with its work on the other Millennium Development Goals (MDGs). For example, many children become ill by drinking contaminated water. MDG 7, which aims to create a sustainable environment, is therefore a vital part of efforts to reduce child mortality rates. There is also a direct link with reducing maternal mortality, covered by MDG 5 (improving maternal health). MDG 6 (combating HIV/AIDS, malaria and other diseases) is also very important, as malaria is a major cause of death among children.

Chapter 3. Better education

Dutch education legislation provides for uninterrupted schooling, thus enabling pupils to undergo continuous development. This process should be linked to individual development so that children can grow emotionally and intellectually. At school, they should acquire knowledge and be taught social, cultural and physical skills. It is also a basic premise of Dutch education that children are growing up in a plural society. Teaching is designed to help pupils become active and well-integrated members of society and also to enable them to find out about and get to know the various cultures and backgrounds of their peers. These principles are laid down in the Primary Education Act 1998 (*Wet op het primair onderwijs*, WPO), the Expertise Centres Act (*Wet op de expertisecentra*, WEC) and the Secondary Education Act (*Wet op het voortgezet onderwijs*, WVO).

Educational matters are explicitly featured in the school plan, the school prospectus, and – in secondary education – the pupils' charter (which is mandatory and subject to revision every two years). These documents emphasise the importance of respecting the views and culture of others.

The Compulsory Education Act makes full-time school attendance compulsory for all children aged 5 to 16, and part-time attendance compulsory for those aged 16 to 18. As from August 2007, compulsory part-time school attendance will be replaced by compulsory study and work experience for all young people up to 18 years old who do not have a basic qualification. Children may attend school from the age of 4. School attendance is also compulsory for minor asylum seekers and asylum seekers' minor children. They are put into bridging classes which prepare them for regular school. In the 2005-2006 school year, fees were completely abolished for all secondary school pupils and for pupils up to the age of 18 years attending schools for secondary vocational education. This means that neither primary nor secondary school pupils are required to pay fees.

3.1 Human rights and citizenship

The Dutch government's education policy is based on the principle that the education sector takes its social responsibilities seriously and makes its own decisions about the way teaching should be organised and provided. It would therefore be inappropriate for the government to interfere in the details of how schools are run. Schools and school boards are given the scope to bear their responsibilities and fulfil their tasks. The government exercises

control over the content of primary and secondary education through statutory attainment targets, which are formulated in general terms.

School is where good citizenship begins, so it is important for young people to give some thought to this concept while they are at school. Citizenship does not belong to a single individual or institution, but to everyone. This issue is addressed directly in the attainment targets in the domain 'Discovering yourself and the world' (*Oriëntatie op jezelf en de wereld*), which covers philosophical issues and topics such as problem-solving and interpersonal skills. The attainment targets help provide the knowledge needed for good citizenship. Under the Active Citizenship and Social Integration Act (*Wet actief burgerschap en sociale integratie*), which entered into force on 1 February 2006, schools are required to promote good citizenship and social integration. The government commissioned a special handbook to help schools put this requirement into practice (*A basis for citizenship*, National Institute for Curriculum Development, Enschede, March 2006). One of the fundamental principles is that Dutch schools, like Dutch society as a whole, do not discriminate on the grounds of gender. The Dutch government's education policy expressly aims to give girls and boys the same opportunities.

The attainment targets for history are designed to enable pupils to make a well-considered judgment based on their own values and those of other people. Similar outcomes are envisaged for the area of learning 'Space', which includes a substantial intercultural component, while religions and beliefs are mandatory elements of the primary curriculum. Within the intercultural component, many schools also focus on peace and international cooperation. Science, environmental education and biology focus on respect for the environment and a responsible attitude to sexuality and health.

Dutch education policy is influenced by international institutions and legislation, but education is not subject to any binding rules. Through exchange of ideas and good practices, the open method of coordination seeks to enable education systems to learn from each other and thus come closer together. International agreements and declarations such as the Universal Declaration of Human Rights and the Convention on the Rights of the Child are also important. In connection with active citizenship and social integration it is important to combat discrimination, in order to guarantee freedom of speech and freedom of religion and allow people to develop their own identity. It is also relevant to encourage young people to have their say in matters which involve them. Education for democratic citizenship is vigorously promoted at European level and the project by the same name has been running for several years. 2005 was the European Year of Citizenship through Education.

Citizenship was a major topic in the debate initiated by the Minister of Education, Culture and Science during the Dutch presidency of the EU in 2004. Making citizenship a core theme in European education was a logical sequel to one of the strategic goals agreed on in Lisbon during the Portuguese presidency in 2000, i.e. active citizenship and social inclusion. The debate was supported by an exploratory study entitled *Citizenship – made in Europe: living together starts at school*, which advocates emphasising the social function of education and the importance of social cohesion and shared values.

3.2 Minority language teaching

Within the Dutch province of Friesland, the Frisian language is used as a medium of instruction in primary education, special primary and secondary education and the lower forms in mainstream secondary education. In theory, everyone is taught in Frisian, so the curriculum needs to allow for the fact that not all pupils speak it as their first language. Secondary school pupils can also choose to take Frisian as an exam subject. Frisian may also be used as a medium of instruction in pre-school education.

The 1990s saw an increase in the teaching of Turkish and Arabic (which are spoken by large numbers of immigrants) in Dutch secondary schools. Schools may now offer these language as examination subjects if they wish.

3.3 Safety at school

A safe and secure school environment is an essential condition for sound education. Schools themselves bear primary responsibility for ensuring a safe environment for their pupils, for instance by addressing the problem of bullying. In carrying out their responsibilities, schools are supported by the government, which introduced new measures in 2004. These included extra investment in social workers and pupil counselling in primary and secondary schools, so that pupils who have or cause problems can be identified swiftly and action can be taken. In addition, provision has been created for pupils with behaviour problems, who are unmanageable at school. Schools can also make use of the expertise and advisory services of the Centre for Safety at School which has a website (pestweb.nl) and telephone helpline. There is also a handbook on how to teach social skills. The Education Inspectorate monitors safety and safety policy. The Inspectorate also employs confidential advisers, to whom schools, parents and pupils can go with complaints about incidents at school involving physical violence, serious bullying, extremism and

discrimination. Schools are required to inform the confidential adviser if there is reasonable suspicion that a sexual offence has been committed.

3.4 Culture and extra-curricular activities

In the Netherlands, efforts are made to introduce all children of school age to the arts. The Culture and School project seeks to promote teaching through and about the arts. To encourage these efforts, the Ministry of Education works with municipal and provincial authorities, cultural institutions and education organisations. Central government mainly focuses on facilities for schools, teachers, pupils and cultural institutions. Many cultural institutions pursue policies on cultural education and there are sectoral cultural institutions with cultural education as their core task. The government has provided extra funding for cultural education, from €4 million in 2004 to €22 million in 2007.

As from 1 August 2007, it will be mandatory for schools to provide wraparound care between 7.30 and 18.30, or arrange for it to be provided by third parties under the conditions set by the school. This will lighten the considerable burden borne by parents and their school-age children, though parents continue to be responsible for caring for their children. The aim is to offer a convenient link between school and childcare, which parents can make use of if they wish. Working parents whose children go to school and are under 12 years old need facilities which enable them to combine their work with their care tasks, and make it easier for them to organise things. The key issue is that every child should have the opportunity to develop its full potential. By entering into partnerships, schools and childcare organisations can make an important contribution. The result should be well-coordinated provision in the fields of education, welfare, childcare, sport and culture for all children.

3.5 Extra educational support

The Dutch primary and secondary education system offers various kinds of provision for children with special needs.

Primary education

To integrate children with special needs into mainstream education, Dutch primary schools work together in consortia (Going to School Together (*Weer Samen Naar School*, WSNS)). These consortia are responsible for providing good quality education to all pupils at the affiliated schools, and to this end they each have a budget for pupils with special needs. Each consortium includes at least one special school for primary education (*School voor*

speciaal basisonderwijs, SBAO). These have extra funding and smaller classes and provide extra help (often temporarily) to pupils who need it. The SBAO also functions as an expertise centre for other schools within the consortium.

Secondary education

Secondary schools (with the exception of those providing senior general secondary education and pre-university education) work together in consortia to provide good quality education to all pupils at the affiliated schools. Each consortium has a special needs budget and there is provision for pupils who have been assessed as eligible for learning support (*Leerwegondersteunend onderwijs*, LWOO) or practical training.

Special education

Pupils with a serious disability, illness or disorder can be registered for Special Education (SO). However, if parents so wish, they may enrol their disabled child at a mainstream school. The pupil will then be eligible for a personal budget which the school will use to provide appropriate tuition. Pupils can only be registered for special education when they have been assessed by an independent committee against objective criteria which are set nationally. A total of 60,000 pupils are enrolled at schools for special education and approximately 20,000 have been allocated personal budgets.

Personal budgets were introduced into secondary vocational education on 1 January 2006. This means that pupils who have been assessed as eligible and want to attend a secondary vocational school can receive support from that school and peripatetic help from a special school. This makes secondary vocational education more accessible and ensures a smooth transition from secondary school to vocational training.

3.6 What does the Netherlands do for children in other countries?

Education is one of the main themes of Dutch development policy. In collaboration with other countries, international organisations and civil society organisations both in the Netherlands and elsewhere, the Netherlands supports developing countries that make and implement sound education plans. Support focuses on the Millennium Development Goals and the goals adopted at the World Education for All Forum in Dakar in 2000. The amount earmarked for education in the development budget is growing. The focus is on basic education, which includes scope for supporting activities in various other subsectors such as vocational education, early years development, HIV/AIDS prevention through education, non-formal education, education for marginalised people and literacy programmes. Strong

public and political support for the Education For All goals and the Millennium Development Goals led the Dutch parliament to pass a motion in 2001 requesting the government to increase the budget for basic education to 15% of the Development Cooperation budget by 2007. This effectively means an increase from about €200 million in 2003 to about €700 million in 2007. The money is spent through bilateral and multilateral channels and through NGOs and civil society organisations.

The Netherlands has bilateral partnerships with Bangladesh, Bolivia, Burkina Faso, Ethiopia, Indonesia, Macedonia, Mali, Mozambique, Pakistan, South Africa, Suriname, Tanzania, Uganda, Yemen and Zambia. The Netherlands provides financial support for the education sector in those countries. The responsibility for drawing up and implementing sound education policy remains with the national governments, in consultation with civil society organisations and other donors. In a number of countries, the Netherlands contributes to other donors' programmes through Silent Partnerships. The Netherlands is also one of the creators and leaders of the Fast Track Initiative (FTI), an international partnership involving donors and governments of developing countries which was set up in 2002 to help speed up education reform. FTI functions as a worldwide platform for giving basic education an extra boost and generating more funding.

The Netherlands provides multilateral support through programmes such as those run by UNICEF, the UNESCO International Institute for Educational Planning, the International Labour Organisation (ILO) and various regional partnerships.

Dutch embassies promote the active involvement of civil society organisations in education reform processes. Many Dutch development organisations which receive development funding are actively involved in basic education. The Netherlands funds an Educational International programme that encourages participation of civil society organisations, teachers and teaching unions in drafting countries' education policies.

Chapter 4. Protection and care

4.1 Youth protection

Children have the right to healthy, balanced development as they grow up. This is mainly the responsibility of their parents. If parents fail to fulfil this responsibility and thus put their children's development seriously at risk, child protection measures may be taken by the authorities. There are two kinds of child protection measures which only the courts can impose. The first is an order divesting parents of parental responsibility, either with or without their consent. The second is to place a child under a supervision order, which means that the parents retain parental responsibility but receive help with the care and upbringing of their children. Since the Youth Care Act (*Wet op de jeugdzorg*) came into force, child protection orders have been implemented by the youth care offices. In addition four nationwide institutions have been mandated to implement child protection orders on behalf of the youth care offices and under their responsibility.

In 2004, the Dutch government took the initiative to improve existing child protection legislation and its implementation through the 'Better Protected' (*Beter Beschermd*) policy programme, which consists of the following projects:

1 Amendment of child protection legislation, with the aim of:

- putting the child's interests (in the sense of growing up in a safe environment) first in all situations;
- adapting the grounds on which child protection orders can be imposed in order to promote cohesion between supervision orders and orders divesting parents of parental responsibility;
- improving the legal position of minors, parents and other interested parties;
- improving supervision of the implementation of child protection orders.

2 Coordinating working methods in the system

Norms are being developed to speed up procedures so that the necessary help can be provided more quickly.

3 Better implementation

Methods are being developed to improve implementation of supervision orders and guardianship.

4.2 Child abuse

The subject of child abuse has received particular attention in recent years. For instance, on 1 June 2003, child abuse was officially defined in the Youth Services Act, which also provided a statutory basis for the Advice and Reporting Centres for Child Abuse and Neglect (*Advies- en Meldpunten Kindermishandeling*, AMKs). The relevant provisions were incorporated into the Youth Care Act which came into force on 1 January 2005.

Prevention

By way of contributing to the prevention of child abuse, the Minister of Justice has submitted a bill which states that parents may not use any form of violence (physical or mental) in the care and upbringing of their children. The bill has since been passed by the House of Representatives and is currently before the Senate

The Ministry of Health, Welfare and Sport has been engaged in introducing a reporting code for professionals working in the childcare, education and youth healthcare sectors. This code provides support to professionals with regard to dealing with suspicions of child abuse.

Experiments involving an integrated approach to tackling child abuse are also being funded in four regions. It is hoped that this will eventually create a parenting support facility, a system for identifying child abuse and adequate care provision. A handbook is expected in early 2007.

Research

Researchers conducting the first study in the Netherlands into the nature and extent of child abuse are expected to present their findings at the end of 2006. Depending on the study's conclusions, the Ministries of Justice and Health, Welfare and Sport will consider whether supplementary policy initiatives are needed.

Domestic violence

The Domestic Violence Programme has been running since 2002 and ends on 31 December 2007. One of its most important elements is the temporary restraining order for perpetrators of domestic violence which makes it possible to ban them from entering their home for a minimum of ten days. The provisions of the bill also apply in cases of child abuse.

The State Secretary for Health, Welfare and Sport has introduced an incentive scheme for Domestic Violence Advice and Support Centres (*Advies en Steunpunten Huiselijk Geweld*, ASHG's). The 35 regional authorities for shelters for battered women have now set them up, adapting them to local circumstances. The ASHG's function as a front-office for the care

agencies responsible for dealing with domestic violence. An arrangement has to be made with these agencies. ASHGs are required to liaise with the AMKs. They are low-threshold and accessible to anyone involved with domestic violence, and they can refer, counsel and support people who seek their help. ASHGs may be part of general social work organisations, shelters for battered women or the Municipal Health Service (*Gemeentelijke Gezondheidsdienst,GGD*), although a few exist independently. The incentive scheme expires on 31 December 2007 and will have been allocated a total of €7.8 million by that date, which amounts to €3 million a year. Municipalities contribute a minimum of 40%, while central government provides a maximum of 60%.

Every year, an estimated 100,000 children witness some form of domestic violence. To enable these children to come forward, some regions have set up special voluntary agreements (*'Kindsporen'*) between the police, the Public Prosecution Service, the Youth Care Offices, the AMKs and sometimes other youth care institutions. The agreements specify the steps to be taken when a child has witnessed domestic violence. At the end of 2006, a list of best practices and a practical handbook will be published, with the aim of encouraging the development of *Kindsporen*.

A national campaign against domestic violence will start in 2007. Children will be among the target groups.

4.3 Sexual exploitation

Youth prostitution

Exploiting a minor to provide sexual services and benefiting financially from this is, as stated above, a criminal offence. The recipient of the sexual services is also criminally liable.

The supplementary measures to the National Human Trafficking Action Plan include a number of extra measures to prevent and combat youth prostitution. One example is the state-funded National Youth Prostitution Information Desk, which supports care providers, policymakers, police and the criminal justice authorities in tackling youth prostitution. The emphasis is on the 'lover boy' problem, underage victims of trafficking in women and male youth prostitution. With regard to investigating and prosecuting cases involving minors, the human trafficking directive issued by the Public Prosecution Service is worthy of mention. The directive states that such cases must be awarded explicit priority. It also points out that underage victims should only be questioned by officers who have received special training.

Child pornography

On 1 October 2002 an important amendment to Dutch sexual offences legislation came into effect. The primary aim of the amendment was to strengthen existing protection from sexual abuse. The legislation implements the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography, the Council of Europe Convention on Cybercrime, and the ILO Worst Forms of Child Labour Convention. The main elements of the amendment aimed to tighten up the prohibition on child pornography by (1) banning computer-generated child pornography; (2) raising the age limit from 16 to 18; (3) changing “having in stock” to ‘possessing’ and (4) abolishing the special grounds for immunity (possession for research, education or therapeutic purposes). The legislation also makes it an offence to be intentionally present at pornographic shows involving children or when pornographic films involving children are being shown in locations intended for that purpose.

It emerged from the first evaluation of the amendment that it has in general increased and improved the scope for tackling child pornography, sexual violence and sexual abuse.

In another attempt to tighten up the approach to child pornography, persons convicted of making, distributing or downloading child pornography have been compelled to provide DNA samples since 1 August 2006. And the Computer Crime Act of 1 September 2006 has extended the scope for detecting internet crime in general. It is now possible, for example, to record telecommunications without the assistance or knowledge of the provider in question. As a result, action can be taken in cases where it is suspected that the provider itself is involved in distributing child pornography.

In 2005, the Digital Technology department at the Netherlands Forensic Institute carried out a large-scale study at the request of the Ministry of Justice into ways of tracing child pornography on the Internet. The results were sent to the House of Representatives. The study will be repeated every two years. The first report has led to the preparation of new legislation which will raise the maximum sentence for professionally producing, distributing or possessing child pornography from 6 to 8 years. The heavier sentence is intended as a signal that the legislature considers these acts to be a serious criminal offence. In addition, the power to record confidential communication using a technical device will be extended to child pornography. Furthermore, in the case of offences carrying a sentence of 8 years or more, the authorities will have the power to enter the homes of suspects without permission in order, for example, to place a device on a computer that will enable them to trace communications with others.

Since March 2006 there have been two sites for reporting child pornography on the Internet. The first is the *Meldpunt Kinderporno op Internet*, a private initiative receiving funding since 1998 from the Ministry of Justice, and the second a police site that falls under the national Cybercrime Reporting Website (MCC). Reports are checked by the National Police Services Agency (*Korps Landelijke Politiediensten*, KLPD), after which websites may be closed down. In addition, an inquiry is to be set up this year to examine the effectiveness of measures to block and filter child pornography on the Internet in the Netherlands.

In spring 2006 the public (Ministries of Justice and Economic Affairs) and private sectors together launched a large-scale publicity campaign to make children and parents aware of the dangers of certain forms of Internet use such as webcams.

Sexual abuse

Under Dutch law it is an offence to perform an indecent act with a person under the age of sixteen. Sexual activity between minors that cannot be regarded as an indecent act is not covered by the legislation. Until 2002, an indecent act with a minor between the ages of 12 and 16 could only be prosecuted following a complaint from the victim. In practice this meant that there were few prosecutions. The aims of this requirement – to achieve a balance between protecting children between these ages from sexual abuse and at the same time, against any infringement of their growing sexual freedom – could be better achieved in a different way. This requirement was dropped as of 1 October 2002. At the same time, a new obligation was imposed on the Public Prosecution Service to enable minors to express their views regarding the act in question. It is of vital importance for minors to be able to express their views not only on the offence but also on the desirability of prosecution. Such a measure provides an extra guarantee that prosecution will follow when appropriate, but not if it would be contrary to the child's interests.

The Minister of Justice is also aware of the way new technology is making sexual abuse much easier. In the spring of 2007, for example, a study will be completed of new channels for sexual behaviour among young people, such as chatting, instant messaging and other forms of sexually charged communication via mobile phones or Internet. These can put young people in a very vulnerable position and may lead to abuse, teenagers engaging in sex for payment, and sex parties involving young people who become the victims of sexual abuse and end up in prostitution (sometimes under the guidance of a 'sugar daddy'). The study will examine the extent to which such behaviour can be regarded as voluntary, and whether it can indeed lead to prostitution.

Sex tourism

The abolition of the requirement that a complaint be made is helpful in efforts to combat sex tourism. In addition, the amendments to sexual offences legislation have broadened extraterritorial jurisdiction to include Dutch nationals and persons permanently or temporarily residing in this country who sexually abuse children outside the Netherlands (articles 5 and 5a of the Criminal Code). Dutch law is applicable even if the abuse in question is not an offence in the country in which it is committed. Such abusers will be arrested and prosecuted in the Netherlands. Suspect persons arriving from high-risk countries at Schiphol Airport can now be detained and questioned.

4.4 Sale of children

The sale of children is a form of human trafficking and therefore a criminal offence. In the Netherlands, trafficking in human beings is taken to mean any exploitation of persons (including those under the age of 18) in the form of forcing them to provide services, sexual or otherwise, and benefiting financially from such acts. Human trafficking and people smuggling go hand in hand. Partly because of this, an Act implementing international law, EU legislation and Council of Europe conventions to combat people smuggling and human trafficking entered into force on 1 January 2005.

The Netherlands has had an independent National Rapporteur on Trafficking in Human Beings (*Nationaal Rapporteur Mensenhandel*, NRM) since 2000. The Rapporteur publishes an annual report with findings and recommendations. She also advises the government, both formally and informally, on a regular basis. The Rapporteur is also concerned with child trafficking. In 2004, in response to her recommendations and findings, the government launched the National Human Trafficking Action Plan plus supplementary measures. In this way the government has made absolutely clear what steps it is taking to improve the approach to human trafficking. These include targeted information to improve the detection and prevention of trafficking, expansion of the number of places available to accommodate women and children under serious threat (including victims of trafficking), agreements with foreign authorities to provide assistance for victims returning to their countries of origin, embedding the investigation of trafficking in the National Crime Squad, regional police forces and other investigation agencies.

4.5 Tackling juvenile crime

The policy of the Dutch government aims to enhance the opportunities available to young people, to prevent youngsters from turning their back to society and thus to prevent young people resorting to crime. The aims of the response to juvenile crime are threefold: as well as punishing the wrongdoer and protecting society, there must be an effort to rehabilitate, in order to prevent repeat offending. Young people must be given the chance to become part of the community again after they have served their sentences.

These aims and premises are the basis of the action programme *Jeugd terecht*, due to run until 1 January 2007. The activities and measures put in place under the programme will continue after that date, with the emphasis on consolidation. The programme targets:

1. Early intervention

To prevent a slide into delinquency the Dutch authorities are focusing on combating truancy and drop-out rates and on providing parenting support.

2. A swift and well-integrated response

Criminal behaviour by young people should be followed by a swift and appropriate response from the criminal justice system. Since March 2003 therefore, a large proportion of the offences committed by young people have been discussed in case consultations (*justitieel casusoverleg*) between the police, the Public Prosecution Service and the Child Protection Board. The aim of the case consultations is to decide rapidly and on the basis of all information available to the partners on an appropriate reaction in each case. The case consultations have led to a reduction in throughput times and have improved the quality of the disposal of cases under the criminal law.

3. Effective punishment

A number of measures have been taken to increase the effectiveness of sanctions:

- * a new measure to enable sanctions to be 'needs-based' in the light of the offender's criminal record and personal problems is proposed in a bill (*'Gedragsbeïnvloeding jeugdigen'*).
- * a commission (*Erkenningscommissie gedragsinterventies Justitie*) has been set up to examine whether behavioural interventions for young people under the criminal law (in order to reduce or prevent repeat offending) are sufficiently effective. Programmes considered to be effective will be included in a handbook;
- * A national framework has been established for testing the current instruments for identifying problems, screening and risk evaluation. The aim is to achieve a

coordinated child-centred set of instruments within the juvenile criminal justice system.

4. Reinforcing rehabilitation

Aftercare can ensure that young people do not slip back into criminal behaviour after detention. It is the aim of the Dutch authorities to provide aftercare for all young people emerging from a young offenders' institution.

4.6 Juvenile criminal law

Lifelong imprisonment

A bill is currently before the House of Representatives which would ban the imposition of life sentences on persons who were 16 or 17 years old when they committed an offence. On the basis of the current article 77b of the Criminal Code, the court may choose to try a defendant of this age under adult criminal law. In theory, the court can then impose a life sentence on a minor for certain offences, although this has never happened in practice.

Right to express views

Since 1 January 2005 the victims of serious crimes have the right to make a statement at the hearing about the consequences of the offence for them. This may be a written or oral statement. Children over the age of twelve, and children under twelve who are considered capable of a reasonable assessment of their interests are entitled to make such a statement.

4.7 Aliens law

Unaccompanied minor asylum seekers

The admission procedure for unaccompanied minor asylum seekers is as follows. They first submit an application for asylum. This is carefully processed, like all asylum applications, and during the interviews and in arriving at a decision account is taken of the fact that the persons involved are minors. The 'burden of proof' is linked to the age of the applicant and is less onerous than for adults. Minors are in principle eligible for asylum and in practice some are successful in their applications.

If a minor is not eligible for protection under the Refugee Convention he/she may be eligible for a temporary residence permit on the grounds of being an unaccompanied minor. The basic premise of this supplementary policy is that unaccompanied minors whose application for asylum has been rejected must in principle return to their country of origin, since

protection under the Refugee Convention is in principle unnecessary. The residence entitlement granted is valid for three years or until the minor has reached the age of 18. If a minor has held a residence permit for three years but has still not reached the age of 18, he/she may be granted a permanent residence permit. However, the principle of return to the country of origin is in the young person's own interests. Very few youngsters who have been uprooted in this way ultimately benefit from the separation from parents or their home environment. The child's interests in principle require the restoration of ties with parents, family and social environment. That is why the authorities check in each individual case whether return is possible and safe.

If it is immediately obvious that the residence permit of a minor will be converted into a permanent residence permit – which is mostly the case with minors who are younger than 15 when they arrive in the Netherlands – then the approach will target integration into Dutch society.

Residence permits held by minors who were older than 15 when they applied for asylum will not automatically be extended. They will have to leave the Netherlands when they reach the age of majority at 18. During the intervening period they are therefore prepared for their ultimate return. This also applies to minors who are not eligible for residence, for example because their parents are still alive.

Protection of children without a residence permit

A child protection order may be imposed in the case of children living in the Netherlands without residence rights. This does not automatically mean that the child may remain in the Netherlands and will be granted a residence permit. However, the Minister for Immigration and Integration has decided that in certain circumstances a residence permit may be granted to a child in this situation. The circumstances and the procedure to be followed are at present the subject of discussions between a number of agencies, including the Youth Care Offices and the Child Protection Board.

Children living in the Netherlands without a residence permit and children involved in an application procedure (the children of asylum seekers, for example) are entitled to attend school. All children of compulsory school age are obliged to attend school in the Netherlands. These children also have access to medically necessary care, and youth care, though the latter with certain limitations.

Children who come to the Netherlands with parents who apply for residence in general have the same interest in being admitted as their parents, at least at the beginning of the procedure. But these interests may diverge if children remain here for a long period of time without residence rights. The fact that a child has lived here for a long period does not automatically mean that he/she will automatically be granted residence rights, but their specific interests and the exceptional circumstances in which these children may find themselves can be taken into account in a separate application procedure and may constitute grounds for granting them a residence permit. Children (or their legal representatives) can themselves submit an application.

4.8 What does the Netherlands do for children in other countries?

The focus in Dutch human rights policy is on child protection in the broadest sense of the word: from combating child labour to protection against violence. Important aims include prevention and assistance for victims.

During the Dutch Presidency of the EU in 2004, the Netherlands worked towards the implementation of the EU directives on children and armed conflict. Through support to a number of organisations including War Child and the Coalition to Stop the Use of Child Soldiers it also hopes to promote demobilisation of child soldiers, assistance for ex-child soldiers and to prevent the recruitment of children.

Activities aimed at combating child labour target prevention, reintegration and rehabilitation for children who are the victims of the worst forms of child labour, promotion of education for working children and the ratification and implementation of ILO Conventions 138 and 183. The Netherlands works through multilateral organisations (UNICEF and the ILO), national and international non-governmental organisations and the social partners. It provides funding within bilateral cooperation for programmes to combat child mortality in various partner countries. For example, in Bangladesh the Netherlands cooperates in an ILO programme that aims to ensure that working children also attend school. In Indonesia the Netherlands will invest US\$24 million over the next few years in an ILO programme for education and vocational training for young people, with the focus on combating child labour.

In 2006 the Netherlands played an active role in the negotiations on the follow-up to the UN's Violence against Children study and will closely follow its implementation. For the Netherlands, the important aspect here is domestic violence directed against children.

The Netherlands supports UNICEF with a voluntary contribution of €28.5 million annually. In addition, it is a major partner in UNICEF's Education in Emergencies, Child Protection and HIV/AIDS programmes, all of which help children in need.

Chapter 5. HIV/AIDS and Sexual Health

5.1 Sex education

Special teaching materials are provided for schoolchildren on discussing sexuality, preventing sexually transmitted diseases (STDs), unwanted pregnancy and sexual violence. They also receive information through other channels (internet, television, youth work). In recent years the government has taken action on STDs through its active test policy, as part of which the municipal health services, together with family doctors, offer free tests and assistance to at-risk groups, which include young people. This work is financed by the government. Since 2004 all pregnant women in the Netherlands have been tested for HIV, so that treatment can be given before and after birth to prevent transfer of the virus to the child.

5.2 What does the Netherlands do for children in other countries?

Fighting the AIDS epidemic and dealing with its consequences are important policy objectives within Dutch development cooperation policy. In Africa there are already at least 15 million AIDS orphans; it is expected that this number will rise to 20 million by 2010. This is taking its toll on the communities to which these children belong.

Children and young people are disproportionately affected by the epidemic. They can be infected during the birth or through breastfeeding, are more prey to abuse, exploitation and violence if they have lost a parent, and are vulnerable to the psychosocial aspects of such a loss. Dutch policy therefore focuses on Children Affected By Aids (CABA), and is expressed through support for UNICEF's work on behalf of such children. Consultations are also held with NGOs on how CABA's needs can be addressed through varying channels, what the problems are and how to tackle them.

As young people are also seriously affected by the HIV/AIDS pandemic, they ought to be the subject of preventative strategies to reverse the tide. One of the reasons the Netherlands is committed to education is because research has shown that the longer young people are in education, the less chance they have of becoming infected. Educational activities on HIV/AIDS are also supported, often in combination with comprehensive sex education. Instruction about abstinence, fidelity and condoms is combined with messages about responsibility, gender and openness regarding sexuality. Young people's rights relating to HIV/AIDS prevention are promoted, such as their right to information and contraception. The

Netherlands also supports increased availability of health services and information and counselling on STDs, and the sale and availability of condoms, test kits and antiretrovirals.

**Netherlands Report for the UN World Summit for Children + 5 Review
ANNEX 1**

President of the House of Representatives
of the States General
Postbus 20018
2500 EA DEN HAAG

Our ref:	Your contact	Tel:	
IBE/E-2637467			
Re:		Enc(s)	Your letter of:
Termination of life (neonates)			

In the position paper on the report entitled 'Medical decisions at the end of life' (Parliamentary Papers, House of Representatives 2003/2004, 29 200 XVI, no. 268) we undertook to inform the House on the subject of unrequested termination of life in the case of neonates. Please see our findings below.

1. Background

Termination of life on request is regulated in the Act on the Termination of Life on Request and Assisted Suicide. Termination of life without a request is an offence under article 293 of the Criminal Code. In certain circumstances, the doctor may invoke the defence of necessity. The patient's suffering must in such circumstances be severe, compelling the doctor to choose between his/her duty to save lives on the one hand and to do everything in his/her power to prevent unbearable suffering on the other. That is never a simple choice, particularly in situations involving unrequested termination of life. If the doctor exercises due care, termination may be justified. What exercising due care entails is dealt with in the Prins ruling (Amsterdam Appeal Court, 7 November 1995, *Nederlandse Jurisprudentie* (NJ) 1996, 113) and the Kadijk ruling (Leeuwarden Appeal Court, 4 April 1996, *Tijdschrift voor Gezondheidszorg* 1996, no. 1).

Terminating the life of a patient in great suffering without a request to that end results in an unnatural death. It must therefore be reported to the Public Prosecution Service, which

investigates the way in which termination took place and decides whether or not to prosecute the doctor in question.

Doctors find this procedure very stressful, since despite their conviction that they acted with due care, they are under suspicion of murder. For this reason, the then Ministers of Justice and of Health, Welfare & Sport set up a consultative group charged with formulating proposals (based on the due care criteria governing medical procedures relating to newborn infants with serious disorders) for a procedure for reporting and reviewing cases in which such procedures had led to intentional termination of life. In 1997 the consultative group published a report entitled 'Toetsing als spiegel van de medische praktijk' (Review as a reflection of medical practice). Its conclusions are in line with the due care criteria set out in the rulings referred to above.

On 29 January 2003 we received a letter from the Royal Dutch Medical Association (KNMG) drawing attention, on behalf of a number of other organisations, to reporting and review procedures in the case of unrequested termination of life.¹ After a new government had been formed, the State Secretary for Health, Welfare and Sport invited representatives of these organisations and other experts to a meeting on 10 February 2004. At this meeting the participants strongly advocated the development of clear reporting procedures for unrequested terminations.

In the summer of 2004, we drew up a position paper on the basis of the findings of the 'Medical decisions at the end of life' report (Parliamentary Papers, House of Representatives 2003/2004, 29 200 XVI, no. 268). In that paper we promised to send a letter to Parliament by the end of 2004 with our views on a response to the need felt by the medical profession for more clarity regarding unrequested termination of life. Further consultations were held to this end, for example in spring 2005 with representatives of the Ministries of Health, Welfare & Sport and Justice, and with the national office of the Public Prosecution Service. Issues discussed included the due care criteria a doctor would need to meet to avoid prosecution for terminating the life of a seriously ill newborn child.

The Dutch Paediatrics Association was also active in this field. In June 2005, it accepted the protocol on actively terminating the life of neonates with a serious disorder (drawn up by Groningen University Medical Centre (UMCG) and thus known as the Groningen protocol) as

¹ The Royal Dutch Medical Association was writing on behalf of the Dutch Paediatrics Association (NVK), the Dutch Psychiatric Association (NVVP), the Dutch Mental Health Association (GGZ-Nederland), the Mental Health Care Confidential Advisors Foundation (Stichting PVP) and the Dutch Voluntary Euthanasia Society (NVVE – now known as Right to Die-NL).

the national guideline. The Public Prosecution Service was involved as a source of information in drawing up the protocol: the Public Prosecutor's Office in Groningen gave the UMCG the 'Medical decisions at the end of life' report, indicating that it seemed to be compatible with existing case law in this field. It emphasised that neither the report nor the protocol should give rise to expectations on how the Public Prosecution Service would deal with any specific case. According to the Public Prosecution Service, the protocol provides sufficient practical information to enable it to assess whether a doctor has exercised due care in terminating the life of a newborn infant.

In addition to seeking greater clarity regarding termination of the life of seriously ill neonates, the medical profession has a similar wish when it comes to cases of late-term termination of pregnancy where the doctor is liable to prosecution. These cases involve terminating pregnancy after 24 weeks in special cases.

In 1999 the government stated in a letter to the President of the House of Representatives that it wished to support careful decision-making in certain cases of late termination where the doctor was liable to prosecution by making it obligatory to report such cases to a central committee of experts for review (Parliamentary Papers, House of Representatives, 1998/99, 26 717, no. 1, pp. 7 and 8).

On the basis of the above developments, we would like to meet the need felt by the medical profession for greater clarity concerning termination of the life of newborn infants whose suffering is severe, and terminations of late-term pregnancy where the doctor is liable to prosecution. In doing so, we bear in mind that it is also important for parents and unborn children for there to be clarity on how doctors deal with the problems outlined above.

2. Scope of the proposal

Before describing the procedure to be followed in terminating the life of seriously ill neonates and in termination of late-term pregnancy, it is important to clearly define the cases in which these are possible options. It is also important to bear in mind that not all cases relating to end-of-life decisions involve an unnatural death. Obviously, if the death is a natural one there is no criminal offence at issue, nor does any special procedure have to be followed.

a. Termination of life of neonates

Children may be born with very poor prospects of survival, or of reasonable health in later life. In such cases, the decision on whether medical treatment has any point is taken on the basis of current medical opinion. It may be clear that the child will die either within a few days or a few months after birth. In such cases, medical treatment is pointless. It is then part of normal medical procedure not to start treatment or to end it. The child in question then dies a natural death.

Another possibility is that, with treatment, the child may have a limited chance of survival, but that its health prospects in later life may be extremely poor. Whether treatment has any point is a question that must then be resolved on the basis of current medical opinion. The attending physician draws up an overall prognosis of the child's current and future health situation, taking into account the relationship between factors such as the expected degree of suffering, life expectancy, the degree of distress involved in treatment, the expected ability to communicate and to be self-reliant, and dependence on the medical/care sector. If the situation is serious, it is normal medical procedure not to start treatment or to end it. Palliative care may be given up to the time of death and may have the effect of shortening life. In such cases there is no question of termination of life: these are natural deaths, and do not have to be reported.

Termination of life is only at issue when the life of a newborn infant is intentionally shortened because of the extreme nature of its suffering. In some cases the child would have died anyway. In other cases, the child might be able to survive but there is no possibility of any improvement in its health, resulting in constant, unbearable suffering with no prospect of improvement. There is also no prospect of an independent life. In these cases palliative care will also be given. However, termination of life leads to an unnatural death which must be reported to the forensic pathologist.

Since most of the cases reported involve serious forms of spina bifida, the impression has unfortunately been created that certain disorders nearly always lead to termination. This is not true. Only the actual degree of suffering can serve as a basis for the decision to terminate life. Patients' organisations have expressed concerns about the misconceptions that have arisen around these disorders. Spina bifida, for example, is in most cases treatable, and patients can lead perfectly acceptable lives. We would concur with this view. Life is worth protecting, and this applies to all of us, disabled or not.

b. Termination of late-term pregnancy

Like termination of the lives of neonates, termination of late-term pregnancy involves the death of a child – in this case unborn – either at or shortly after termination. In this connection it is important to recall the distinction between category 1 and 2 cases (see the letter from the government to the President of the House of Representatives of 6 September 1999, Parliamentary Papers, House of Representatives 1998/99, 26 717, no. 1 concerning termination of late-term pregnancies). Below we discuss this distinction in greater detail.

Partly on the basis of the premises and conclusions of the report entitled ‘Termination of late-term pregnancies: due care and review’ published by the consultative group set up to consider this issue, the following definition was drawn up. Termination of late-term pregnancy is a procedure that aims to terminate a pregnancy after 24 weeks because a serious foetal disorder has been diagnosed and which results in the death of the foetus. The report states that it may be acceptable according to prevailing medical standards to terminate the life of an unborn child. It distinguishes between two categories of serious foetal disorders where late-term termination may be considered acceptable.

Terminating a pregnancy falls under article 296 of the Criminal Code in conjunction with the Termination of Pregnancy Act. On the basis of medical opinion, the point at which a foetus becomes viable outside the mother’s body has been set at 24 weeks’ gestation. In other words, under article 296, paragraph 5, termination of pregnancy up to 24 weeks is not a criminal offence provided the requirements laid down in the Act are complied with. After 24 weeks, however, article 82a of the Criminal Code applies. This article makes it an offence to kill a foetus that might reasonably be expected to have survived outside the mother’s body.

Category 1 cases are those in which the unborn child cannot reasonably be expected to survive outside the mother’s body. The disorder is untreatable. The baby is almost certain to die during delivery or immediately after birth. Because of a serious congenital disorder, the foetus is not viable and will never be so. As a result, the reasoning behind article 82a becomes inapplicable, since the aim of the article is to protect the life of the viable unborn child through the criminal law, and termination in these situations falls outside its scope. Although terminating the life of a foetus that is not viable independent of the mother does not fall under the scope of Article 82a, it nevertheless remains within the scope of article 296, paragraph 5 of the Criminal Code which, as indicated above, states that termination is not an offence if the requirements of the Termination of Pregnancy Act have been met. In such cases the public prosecutor is not required to decide whether or not to prosecute. However, the termination must be reported, under the Burial and Cremation Act, to the municipal forensic pathologist, who in turn informs the public prosecutor. The reason is that an

unnatural death has taken place, since late-term termination is an active intervention whose aim is the death of the foetus. The Dutch Association of Obstetricians and Gynaecologists established guidelines at a meeting of its members in November 2003 describing the decision-making procedure preceding late-term termination for category 1 cases. The guidelines also provide for a form of peer review and an appeals committee decides whether the doctor acted with due care. The guidelines take into account the statutory provisions.

The second category covers fetuses that have anomalies leading to serious and incurable functional disorders but which might reasonably be expected to have a chance of survival, although mostly a very limited one. Without medical intervention, the disorder will result in death. Medical intervention will however lead to lifelong suffering and may even be deemed to be harmful. Termination of pregnancy in the case of disorders falling into this category nevertheless falls within the scope of article 82a of the Criminal Code and is therefore in principle an offence. Invoking necessity as a ground for immunity from prosecution may in some cases be successful. But necessity can only be successfully invoked if it has been established that according to prevailing medical opinion, the disorder affecting the foetus is of such a nature that medical intervention after birth would be pointless from a medical point of view.

3. Review procedure

We would propose the following procedure on the basis of the documents, case law and principles referred to above.

Terminating the life of neonates who are in great suffering and termination of late-term pregnancies falling in category 2 remain offences. Our choice would be to set up a committee to provide the Public Prosecution Service with expert advice in specific cases. The attending physician who terminates the life of the neonate or the late-term pregnancy does not draw up a death certificate, but reports the death under section 7, subsection 3 of the Burial and Cremation Act to the municipal forensic pathologist by filling in the form prescribed in article 2 of the Royal Decree of 6 March 2002 (Bulletin of Acts and Decrees 2002, 140). The municipal forensic pathologist carries out a post mortem and informs the public prosecutor by filling in the form prescribed by Royal Decree of 17 December 1993 (Bulletin of Acts and Decrees 1993, 688) for neonates or that prescribed in article 3 of the Royal Decree of 6 March 2002 for late-term terminations. The forensic pathologist has to enter on the form his conclusions as to the pathology of the disorder and whether another doctor was consulted. Currently, the forensic pathologist sends these documents to the

public prosecutor. Under the proposed arrangement, the forensic pathologist would send them to a central five-member committee of experts consisting of a chairperson, three physicians (sharing a single vote) and an ethicist. The three physicians would be specialised in paediatrics, for example a neonatologist and a child neurologist, with a gynaecologist in the case of late-term terminations. On the basis of the criteria set out below, the committee will decide whether the doctor acted with due care in terminating the life of the neonate or the late-term pregnancy. The committee's decision will then be forwarded to the Board of Procurators General. The Board then assesses whether the doctor has complied with the criteria and may take account of the committee's decision in deciding whether or not to prosecute. The committee's decision does not therefore replace the public prosecutor's decision, but serves as a form of expert advice. If the Board decides to prosecute, the relevant public prosecutor will be charged with instituting proceedings. But not every failure to comply with the due care criteria will lead to prosecution.

The proposed procedure will be laid down in an instruction from the Board.

The procedure will benefit both the Public Prosecution Service and doctors. The standards laid down and the decision of the committee offer doctors the certainty that the case will be assessed not only from a legal perspective but also from a medical and ethical point of view. In addition, doctors will have guidelines to follow in situations involving unrequested termination of life and of late-term pregnancies, putting an end to their uncertainties on these issues.

4. Due care criteria

Terminating the life of neonates who are in great suffering and termination of late-term pregnancies falling in category 2 call for the highest possible standards of care. The criteria against which such actions will be assessed have been taken from case law and the reports referred to above. The Public Prosecution Service will take these criteria into account when deciding whether or not to prosecute. The committee of experts will take them into account when deciding whether doctors have acted with due care.

In terminating the life of a neonate, the physician has acted with due care if:

- a. according to prevailing medical opinion, the child's suffering was unbearable and without prospect of improvement, which means that the decision to withhold treatment was justified. There was therefore no doubt about the diagnosis and prognosis, in the light of prevailing medical opinion;

- b. the child's parents gave their consent;
- c. the physician fully informed the child's parents of the diagnosis and prognosis. This means that together with the parents the physician came to the firm conclusion that there was no reasonable alternative in the light of the child's situation;
- d. the physician consulted at least one other, independent physician who saw the child and gave a written opinion on compliance with these due care criteria. Alternatively, the physician could have asked for the views of the medical team attending the child;
- e. the termination was performed with due medical care and attention.

In terminating a late-term pregnancy, the physician acted with due care if:

- a. the foetus had a disorder falling into category 2, which means that it was of such a nature that after the child had been born medical treatment would have been withheld on the grounds that it would be pointless from a medical point of view according to medical opinion. In other words, there was no doubt about the diagnosis or the prognosis according to prevailing medical opinion. What is more, in that same medical opinion, continuing the pregnancy would have made no meaningful contribution to a more accurate diagnosis;
- b. the child was currently suffering or could be expected to suffer, with no prospect of improvement;
- c. the mother had expressly asked for the pregnancy to be terminated because of physical or mental suffering caused by the situation;
- d. the physician fully informed the child's parents of the diagnosis and prognosis. This means that together with the parents the physician came to the firm conclusion that there was no reasonable alternative in the light of the child's situation;
- e. the physician consulted at least one other, independent physician who gave a written opinion on compliance with these due care criteria. Alternatively, the physician could have asked for the views of the medical team;
- f. the pregnancy was terminated with due medical care and attention.

It is important with a view to assessing the due care criteria for the attending physician's report to give the municipal forensic pathologist an accurate picture of whether they have been complied with. The report form will therefore be supplemented with questions relating to the criteria.

5. The committee's composition and method of operation

As indicated above, the committee will consist of five members: a chairperson, three physicians from different paediatric disciplines, and an ethicist. The chairperson will be a lawyer. All members will be appointed for a period of six years by the State Secretary for Health, Welfare and Sport and the Minister of Justice. They may be reappointed for a further six years. The committee will be assisted by a secretary, who will have an advisory vote at meetings. The committee members may be discharged at their own request or for unsatisfactory performance. They will receive an attendance fee and travel expenses in accordance with existing rules for public servants.

In order to assess a case, the committee will be empowered to ask the physician who performed the termination to explain his actions in writing or orally. It may also request further information from one or more members of the medical team concerned. In addition, the committee may consult third parties depending on the specific expertise required.

The committee's decision will be based on the due care criteria set out above. It can only be finalised once all committee members have voted. The Public Prosecution Service is then informed of the decision, which it may take into account as a form of expert advice in deciding whether to prosecute. If the decision is that the doctor did not comply with the due care criteria, the Health Care Inspectorate will be informed. The attending physician receives a copy of the decision. A version of the decision (with all names removed) will be published in a databank open to the public.

The committee members have a duty of confidentiality and may decline to give evidence. The committee issues an annual report to the State Secretary for Health, Welfare and Sport and the Minister of Justice. It is set up by ministerial order and has its own rules of procedure.

6. Conclusion

We believe that this proposal meets the demand from the medical profession and others for more clarity concerning the application of the criminal law to termination of the life of neonates and of late-term pregnancies. The due care criteria and the reporting form provide a uniform structure to guide attending physicians through the various procedural steps and in answering all the questions relating to compliance with the criteria. They can thus assist physicians in dealing with these very difficult situations. This does not mean, however, that physicians can ask the committee of experts for advance approval of a termination of either kind. The committee reviews actions that have already been taken.

We recognise too that in recent years much work has been done in the various medical organisations and consultative groups referred to above with the aim of achieving a sound medical and legal approach to these issues. Their work has been most valuable to us in arriving at the proposed arrangement.

Clémence Ross-van Dorp
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Piet Hein Donner
Minister of Justice